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Reflections on the role of consultant radiographers in the UK: What is a consultant radiographer?

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ABSTRACT

Context: This paper is the second paper from a two year in depth case study, exploring the role of consultant radiographers in the UK.
Methods: A longitudinal case study approach was used to determine the role of consultant radiographers. Interviews were used to explore experiences of being a consultant, which were analysed using thematic analysis.
Eight consultant radiographers participated (Note, two of the consultants withdrew after the first interview due to workload). Therefore two consultants were interviewed only once. The remaining six consultants were interviewed twice over a 12 month period.
Findings: The data presented in this paper explores the nature of the role, differences between roles, the four domains of practice, and how the role fits into local organisational structures.
The study shows wide variation in the types of roles undertaken, reflecting that the creation of these roles were in response to local clinical need and often related to an individual practitioner's skills. The broad scope of the role was shown across all the consultants, with evidence of roles developing into new areas of service delivery.
Conclusions: The paper offers insight into the role(s) of consultant radiographers in the UK. The range and scope of their practice is extensive, with much variation. It is evident that the clinical aspect of the role dominates, with research being the least supported domain of practice. There remains a lack of clarity around the role, with concerns about remuneration and other limitations that may restrict the role developing further.

Background

The introduction of non-medical consultants in nursing and allied health professions in the UK has been stated[1] as a means to 'achieve better outcomes for patients' and to enable experienced practitioners 'to remain in clinical practice'.[2] To this extent, a Consultant Radiographer is defined as an individual who: (a) provides clinical leadership within a specialism, and (b) brings strategic direction, innovation and influence through practice, research and education".[3]

The initial high level of publications around consultancy in radiography has declined in recent years, with only 4 new articles being identified in 2014–2015. Moreover, two of these[4,5] pertain to role-transition issues, rather than the constitution of consultancy itself. While no specific and definitive role outline and progression pathway is extantly available, key guidelines for the role of non-medical consultants have been documented.[6,7] The Consultant Radiographer role is generally described within four domains of practice: expert practice; professional leadership/consultancy; practice/service development, research/evaluation and education/professional development.[8] Guidelines were published initially to suggest that a minimum of 50% of an appointee's time would be spent in clinical practice,[9] with the remaining 50% being spread across the three other domains of practice (contingent upon on local need). There is some contemporary evidence to suggest that research/evaluation is the domain to which the least time is commonly devoted,[10,11] but little regarding the distribution of investment across the other domains. As such, a national picture of how these roles 'look' in practice remains largely elusive. It is also apparent that the development pathway for consultants is

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not well delineated,[10] and its operations are often *ad hoc* in nature.[12] In radiography, Price and Edwards[13] report that there is a "lack of clearly defined clinical and educational pathways," a view supported by conversant studies,[8,14] raising questions over the preparation actually required for a consultant role in the first place. Without precursory clarity regarding the composition of the role (and the four domains of practice therein), it is challenging to specify the exact nature of preparation that would be beneficial.

Given the rather murky waters surrounding issues of role clarity in UK consultant radiography, this paper reports findings from a longitudinal, qualitative study exploring the personal experiences of the consultants themselves. Drawing on accounts of their everyday activity, the scopes of their practice and how their roles have evolved.

Methods

This paper forms part of a wider study, funded by the College of Radiographers Industry Partnership Scheme (CoRIPS). The research reported herein specifically addresses the first and second rounds of in-depth interview, which were undertaken in 2010 and 2011. These focused on the nature of the role in practice, and are context and situation specific, thus reflecting the singular nature of each participant's experience.

All consultant radiographers who were working in the UK and registered with the College of radiographers (CoR) in 2009 were invited via the consultant radiography group (CRG): an electronic invitation was sent via the chair of this group. Initially nine consultants agreed to take part; however, one withdrew before the first interview leaving 8 participants. Two more withdrew after the first round of interviews was conducted. Consequently, 14 interviews were conducted, with six consultants being interviewed twice over a 12 month period, and two consultants being interviewed once. To ensure participants from around UK were able to participate the interviews were undertaken by telephone. All data were recorded using an Olympus VN-731 Digital Voice Recorder to capture both sides of the conversation, and then transcribed verbatim.

Interviews were largely open and semi-structured in form, to facilitate each consultant's capacity to describe their own role in their own way. Topical probing was used to help extend and deepen their narratives where necessary, and iterative interviewing was used to build on the topics covered.[15] The interviews moved from discussing role establishment in the first round, to undertaking the role in practice during the second.

Every effort was taken to reduce possible bias in interview questioning and during the analysis of data. An experienced qualitative researcher (a radiographer/academic not involved with the consultant group) undertook all interviews and a second experienced qualitative researcher (also a radiographer/academic; again not involved in the consultant group) analysed the data. This ensured any bias in questioning would be apparent and data removed if necessary. The first researcher reviewed the analysis so that agreement on themes could be established, thus minimizing bias in analysis and interpretation of data. As a final check, interviewees were sent their transcripts to check for accuracy and to establish appropriateness of interpretation.[16] Thematic analysis, using a word and phrase level coding process established initial codes, which were then grouped into higher order themes.[16] The paper reports on the main themes raised by the consultants, using examples which exemplify points being raised.

Discussions with the National Research Ethics Service (NRES) around the purpose of the study determined that full NHS research ethics review (NHS REC) was not required.[17] However the research followed good ethical practice guidelines as stipulated by the University of Cumbria Research Ethics Committee.

Overview of findings

The core themes that emerged from the thematic analysis were:

- The role itself:
  - Scope and developments
  - Evolution of the role
  - Four domains of practice
- Frustrations and inequalities
  - Agenda for change and pay banding

These themes are discussed below with reference to pertinent literature, incorporating extracts from the interviews to ground them in the practical experience of participants themselves.

Findings and discussion

During the interviews, participants were asked to describe their role and the scope of their practice. While there was huge variation across the accounts provided, this is consistent with the well-documented knowledge that each such position is unique, and activities are primarily contingent upon the skills and expertise of the individual, and local clinical needs.[1] There was clear convergence on the notion that the roles promoted 'autonomous practice', although the specific meaning of this was not substantially unpacked by the participants:

> *I think as well when you move into these roles you very much … have autonomous practice* (1:001)

> *I would emphasise the fact that I work independently and autonomously … with a big emphasis on decision making and … responsibility* (1:005).

It was argued that the role was different from that of an advanced practitioner though, again, the consultants did not develop an account of how these roles diverged. They did, on the other hand, identify 'role expansion' and 'wider, network–level interactions' as key components:

> *As an advanced practitioner … you don't have such an expanded role* (1:008)

> *I think advanced practice whilst it is starting to identify areas of service need … it would be working within a local area rather than at a network level* (1:008)

There was diversification of position as to whether a consultant radiographer undertook the same role as a Radiologist or Oncologist. To some extent this appeared to be discipline-specific. In radiotherapy the role was framed oppositionally:

> *I have my own discreet set of skills which are synergistic with my colleagues … I have a very definite role which is not a pseudo-oncologist– it is a consultant radiographer role and we all work together* (1:005)

> *If that patient comes in and I suspect they've got anything else going on – any other clinical issues – then they are directed to the Oncologist because I can't deal with that. So our roles are very different* (2:009)

With respect to diagnostic specialities, however, and particularly in breast services, this was not viewed as the case. Instead, a much greater symmetry between the roles was posited:

> *As a breast consultant radiographer, we are working the same as a consultant radiologist … we do new patient clinics …* where we